Chapter 2

Ethical Issues

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Introduction

Most professional organizations whose members deal with trauma victims have published ethical standards for treatment-related issues. Examples include the *AAMFT Code of Ethics* published by the American Association of Marriage and Family Therapists, the *Ethical Principles for Psychologists* published by the American Psychological Association, the *Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry* published by the American Medical Association, and the *Ethical Standards of the American Association for Counseling and Development*. The concerns expressed in these documents apply to the treatment of all patients. However, case histories about otherwise competent clinicians who slip into murky ethical territory indicate that trauma is at the center of clinical controversy with remarkable frequency.

In part, the high frequency of confrontation with ethical dilemmas in the trauma field may be due to the legally and morally complex results of maltreatment, such as sexual promiscuity or sexual acting out (Burgess et al., 1987), suicidality (Bryant & Range, 1997), and disorders of attachment that lead to manipulative or dishonest behaviors on the part of child and adult clients (Briere, 1992). In other words, the symptoms and diagnoses that most often complicate treatment co-occur frequently with trauma.

Additionally, treating such clients can produce feelings and thoughts in the therapist that may increase the likelihood of ethical struggles and transgressions. We note with respect the difficult clinical tasks that our readers have chosen to undertake. We therefore strongly recommend that any therapist treating victims of crime should seek out professional consultation in difficult cases.

Credentials and Training

It is the ethical duty of the therapist to choose treatments that have support in the available professional literature as beneficial to children exposed to crime, and to seek appropriate training for competent provision of such treatments. The "Provider Qualifications" chapter defines the general qualifications for clinicians working with the Victims of Crime Program. However, as reflected in the Treatment chapter, many psychotherapy options are available to meet virtually any treatment goal. This task force recommends that therapists applying to treat victims of crime within this program demonstrate the following:

- They are credentialed within at least one specific treatment modality, including the training and supervision applicable to child clients.
- They are aware of the professional literature giving support for use of their modality of treatment with the target population.
- They are aware of the specialized ethical standards applicable to their modality of treatment.

Any therapist treating a victim of crime must provide a treatment plan. This plan is predicated on a theoretical and empirical understanding of how and why such treatment should work. The ethical mandate for the therapist includes such an understanding, especially since patients (or patient guardians) have a legal and ethical right to be informed about other unchosen treatments that may be equally or more effective for their needs. It is a useful task for the therapist to write a one to two-page description, in lay language, of the primary modalities of treatment that are employed and how (or why) they are thought to affect symptoms and behaviors. This description can be made part of informed consent (see the "Clinical Documentation"

chapter). Supervisors of student therapists have the responsibility to ensure that the supervised therapist is knowledgeable about the safe and effective application of the relevant treatments.

While there must be room for therapeutic innovation, the therapist should also know the scientific foundation for the treatment. "No program of psychotherapy should be undertaken," write Koocher & Keith-Spiegal (1998), noted experts on the ethics of psychotherapy, "without a firm theoretical foundation and scientific basis for anticipating client benefits" (p. 109). These authors do not demand large-scale empirical proof of treatment efficacy, although this is desirable, but they do require scientific evidence for the foundations of the treatment. For instance, "exposure" therapies (systematic desensitization, integrative cognitive behavioral therapy, or cognitive processing therapy) rest on firmly established behavioral principles. They have demonstrated their efficacy in controlled experiments, have been implemented in differing ways, and plausible arguments can be made for their effectiveness. On the other hand, regressing a teenager to infancy for "radical reparenting therapy," or shouting at a child in "rage control" or "harassment therapy," has led to ethics complaints to professional organizations (Koocher & Keith-Spiegel, 1998). Further, these techniques are not derived from accepted psychological principles. Such therapies often rest on "unique theories of causation," a criterion used by Chadwick and Krous (1997) to identify irresponsible medical testimony in child abuse cases.

A therapist who uses a new or innovative treatment, or a treatment that has been seriously questioned in the empirical literature, bears a special responsibility to child clients and their families. A child's guardian has a right to know whether alternative therapies exist. The corresponding ethical duty of the therapist using a controversial treatment is to:

- Be able to explain the risks and benefits of proposed and other alternate treatments.
- Be well-versed in the specific nature of the controversy related to the innovative treatment, so that the patient can be best protected.

It is not sufficient simply to dismiss one's critics as not fully acquainted with the therapy, or to continue using an ineffective therapy because it was the preferred treatment in the clinician's educational settings. A review of the strategies covered in the "Treatment" chapter can provide directions for further relevant education and training for the clinician treating traumatized children.

Neutrality and Objectivity in Assessment and Treatment

The treatment of a traumatized child can be an involving and emotionally disturbing process for the therapist. Continuing self-evaluation, attention to self-care and areas of personal vulnerability (such as the therapist's own trauma history), access to peer support and availability of consultation for complex cases are crucial to effective work with this population. Admonitions that the therapist should remain "neutral" or "objective" are common in texts on ethical treatment of traumatized children and their families. Equally common is the recommendation that the therapist show empathy and involvement with the client. Empathy for the client on the part of the therapist, together with the client's recognition of this empathy, are among the most well-known predictors of client improvement (Mays & Franks, 1985; Strupp et al., 1964).

Therapists often anecdotally report a perception of conflict between the requirement for involvement and empathy and the requirement for neutrality. The societal stereotype of the neutral and objective scientist — an individual who shows no emotion as the work is conducted — is antithetical to the empathic professional image we prefer to project. We wish to state clearly that we do not expect the therapist to be neutral to the possibility of further trauma to the child or neutral to the child's pain. Communications of caring need not be (and typically are not) ethically questionable.

The neutrality that is expected of the therapist is noninterference with the child's "freedom to discover" (Brown et al.'s [1998] term). As is true in many arenas of ethical clinical work with children, this is not an easy task. It is worth remembering that the clinician who superimposes his or her view of reality on the child

treads dangerously close to the behavior of the abuser who denies the child's reality and needs and substitutes his or her own (Davies & Frawley, 1994). The therapist should not be telling the child what did or did not happen in the trauma setting or claiming to know what the child did or did not feel. The therapist may raise possibilities, model acceptance of varying emotional reactions, and show curiosity about the child's internal state.

In the interviewing of children, the ethical clinician must be aware of the developmental changes in children's language. An excellent review of the capacities of young children and their weaknesses in comprehension when interviewed in an inappropriate way is provided by the American Bar Association Center on Children and the Law (Walker, 1994). Such sources also aid the clinician in understanding the child's "inconsistencies." For example, a 5-year-old boy may deny seeing "some things the bad man did" because he believed he saw all of these acts (Beck, 1982) or may deny remembering the crime because he never forgot it (Walker, 1994).

Neutrality and Memories of Trauma

As will be argued below, the ongoing forensic aspects of a child trauma case may lead the therapist into ethical difficulties as he or she confronts the variability in child testimony. Fearing that a child victim might be facing considerable pressure at home to accuse or to recant, the therapist may fall into a pattern of counter-suggestion. It is not unusual to hear anecdotal accounts of therapists (or forensic interviewers) telling a child that the truth is known by the adults, when this is not in fact the case ("We know you are lying; tell us the truth."). While the danger that the child will develop a "false memory" appears not to be great in a non-coercive therapy environment (cf. Brown et al., 1998), the child's wish to please a parent or therapist may lead to false statements to one or both valued adults. The message sent by the therapist to the child should be that the child's safety and happiness is valued, not that one legal or custodial end (punishment or avoidance of a specific person) is desired.

The realities of treatment with a child who is also the center of a legal battle can place a strain on therapist and client. It is extremely likely that suggestive influences will occur in such circumstances, and it is the rare therapist who can completely hold himself or herself apart from these influences. Consultants are enormously valuable in such circumstances, and are recommended as part of any ongoing therapy practice with abused children. The ethical responsibility here is to strive to support the child's developing mind, sense of reality, capacity for attachment, and social and personal responsibility. It is useful to clarify for the child that adults may want him or her to say something that may not be true. Often the child is the only witness to the crime in question, and must be reminded that the perceived omnipotence of adults does not extend to knowing the details of what actually happened during the crime event.

The therapist's wish to believe or to disbelieve may be particularly strong in situations in which the crime against the child was allegedly very severe or involved rare or unusual features. Here the therapist may do harm to the child by imposing a particular interpretation on a confusing set of features without sufficient external collaboration (positive imposition of reality), or by prematurely labeling a child's understanding as "impossible" or "fantasy" (negative imposition of reality). Both types of therapist behaviors can cause significant damage in the child's life.

An example of positive imposition of reality would be a therapist who interprets ambiguous statements from the child as necessarily indicating child abuse and who communicates this to the child. Overinterpretation of a child's drawings or play might lead a therapist into this dubious ethical territory; in fact, no single test finding should produce certainty in a therapist's mind that a child has been traumatized or abused. On the other hand, a child who is acting out and/or shows developmentally inappropriate knowledge of sexuality should raise the therapist's index of suspicion.

An example of negative imposition of reality would be a therapist who tells a child that he or she must have a false memory of the crime without certain knowledge of what actually occurred. Therapists treating this population should know that implausible or impossible detail is not a rare event in the accounts of children

who are later proven to have been abused (Dalenberg, 1996). Thus, inconsistencies or fantastic detail should not lead a therapist to assume that the entire allegation is false.

Finally, trauma has been shown to produce fragmented memories that may be distorted or "dissociated" (Brown et al., 1998; Courtois, 1999). Memory impairment after trauma has been noted in cases of combat (extensively reviewed in Brown et al., 1998), torture (Goldfeld et al., 1988), adult rape (Elliott & Briere, 1995), and child sexual abuse (Brown et al., 1998). These findings (a) underline the necessity for the therapist to carefully monitor the possibility of influencing recall, and (b) suggest that delayed recall or delayed disclosure need not indicate that the account is not trustworthy.

Neutrality and Diagnosis

Issues of neutrality also at times come to the attention of ethics boards or institutional review boards when a therapist overuses a particular diagnosis. Use of broad checklists to diagnosis "subtle" cases of a given diagnosis can be problematic. Therapists are well advised to consider the diagnostic issues described in the "Assessment" chapter, and to recognize the responsibility to diagnose through valid and reliable means.

A significant problem in the diagnosis of child crime victims is the tendency to overdiagnose posttraumatic stress disorder (or PTSD) based on clinical interview alone (Jacobs & Dalenberg, 1998). Such overdiagnosis may be due to lack of awareness of diagnostic criteria or to mistaken notions as to the consequences or lack of consequences of this diagnosis. Decisions to fund or not to fund a given claim in the Victims of Crime Program do not require the child to have a specific Axis I or Axis II diagnosis. The therapist must take care not to follow a diagnostic agenda, seeing symptoms where he or she believes they should be rather than assessing the reality of the child's emotional situation. Diagnoses may have consequences for the child's future, potentially affecting family insurance premiums and influencing the diagnoses of future therapists by providing context for the child's future symptoms. Further, the most effective treatment for the child may differ depending on diagnosis. A treating professional owes a duty to the child and his or her guardian to carefully and accurately evaluate the child victim of crime, staying open to the possibility that the child's pattern of symptoms fits no diagnostic category (perhaps despite the severity of the potentially traumatic circumstances).

Understanding the Role of the Therapist

The therapist should avoid assuming dual relationships in the system, for example, serving both as forensic evaluator and as a therapist; or treating a child when a pre-existing personal or professional relationship exists with the alleged perpetrator of the crime against the child.

The therapist of a child victim of crime often becomes involved in the legal system without making a specific choice to do so. Testimony may be required from the treating professional on a number of subjects, including current and past symptoms, disclosures made during therapy, and likely prognosis. The potential impact of the clinician's notes on the legal process underlines the necessity to prepare a professional file (see the "Clinical Documentation" chapter). However, the clinician must ensure that the ongoing or upcoming legal process, if any, does not dictate the course of therapy.

In the treatment of child witnesses to or victims of crime, one frequent source of confusion is the role of investigation in treatment. An initially nondisclosing child who begins to talk about his or her traumatic experience, or a disclosing child who recants, may trigger a change in legal circumstances that the therapist may view positively or negatively. It is not an ethical obligation of the therapist to engage in an investigatory process, or to slow or increase the pace of disclosure to meet investigatory purposes. In fact, it is advisable for the therapist not to interrupt the ongoing process of therapy in order to investigate the crime for forensic purposes. If reportable disclosures occur, further discussion with the child about the incidents within therapy should be undertaken only as clinically indicated. The therapist should report important disclosures to the child's guardian or legal representative, allowing forensic interviewing to take place as a separate process. The therapist may be the only adult figure who places the child's clinical needs above requirements of the legal case.

Protection of the individual needs of the child should also be the primary motivation for decisions about the structure of the child's therapy. The therapist for an adult, for example, should not take on the individual therapy of that adult's child after an accusation of child abuse, although this therapist may play a role in family therapy. Similarly, professional acquaintances of an adult accused of a crime against a child should not take on the therapy of this child.

Working within the Child's Support System

The task of the therapist is not to substitute for the child's family system, but to provide support, structure and treatment for the child and his or her existing support system or to facilitate the development of a new support system.

Another route for ethical difficulties for the clinician working with the child victim of crime flows out of the therapist's wish to rescue. A child's pain and very real physical needs are compelling to compassionate therapists, as they should be. The easiest route to easing the child's pain in the short run, however, may not be good for the child in the long run. As an example, to the extent that the therapist undermines the child's relationship with his or her parent by criticizing the parent's character, the child will feel less able to make internal use of the parent as a soothing and supportive figure. While work with abused children may make this aspect of the therapist's job quite challenging, the therapist must try to be useful to the parents or guardians in their quest to strengthen and deepen the parent-child relationship. The therapist strives to help parents perform these functions more effectively rather than replacing the parental figures in important aspects of the child's life. This is a key facet of the "nonmaleficence" rule in medicine and psychotherapy: first, do no harm.

Cultural Sensitivity in Trauma Treatment

The mental health professions have only recently come to understand how culture impacts the assessment and treatment process. Such considerations mandate the use of assessment instruments that are adequately normed and validated across cultures. In selecting assessments, the clinician is required to know that the chosen instrument meets these requirements. Specifically:

- Does the individual meet the language requirement for the test? Most psychological instruments specify a reading level requirement for valid interpretation. If the person being tested does not meet this reading level in English, but they do so in another language, the evaluator should consider the possibility of obtaining foreign language versions of the basic tests. The MMPI and MMPI-2, for example, have been extensively studied across language and culture groups, and can be obtained in Spanish, Chinese, Japanese, Vietnamese, Hebrew, Italian, and other languages.

- Is the individual being tested a member of the group upon which the norms for the instrument were based? The newer MMPI-2, for instance, is normed on a sample of Americans chosen to ensure regional representation and ethnic diversity. The older MMPI was normed on a small group of Caucasian adults selected in part for their lack of physical and mental health problems. The former instrument is thus more appropriate for use with diverse populations. Many instruments also have published norms for special groups (for example, intelligence or neurological test norms for older persons or norms for racial groups on personality scales).

- Has the instrument been validated within the group to which the individual belongs? The evaluator should have knowledge that the instrument does indeed predict or relate to the criterion behaviors within the referenced culture. That is, does Instrument A, meant to measure delusions, do so for Hispanics, or Asians, or for Caucasian Americans only?

Those involved solely in treatment cannot avoid the dilemmas brought to our attention by cultural researchers simply by stating that they do not treat members of this or that cultural group. "Multicultural counseling is not an exotic topic that applies to remote regions," Pederson et al. (1989, p. 1) write, "but is the

heart and core of good counseling of any client." Thus, goals for treatment should be developed cooperatively with the family, understanding that many values (for example, independence, family loyalty, and achievement) are culturally derived and culturally dependent. Cultural sensitivity may involve appreciation of the value difference, as in the example below:

> L.H. came to the United States with her Asian parents when she was 10 years old. Both parents work in a computer firm owned by a family relative, and the family lives and socializes almost solely with other relatives and family immigrants. L.H. has become a problem for her family over the last 5 years as she has assimilated into a diverse American subculture within her school. After an episode of stealing, her mother slapped her and both parents stopped speaking to her or acknowledging her existence, although she continued to live at home. A teacher, hearing about the child's despair, made a child abuse report.
>
> The evaluator, on hearing this story, sympathized strongly with the child's felt need for independence and considered the parental reaction to be abusive and neglectful. She tried to make the case for greater openness and acceptance within the family, but she was not able to make headway. A consultant to the case was able to make significant positive progress by helping both parent and child to understand and appreciate the cultural differences that led to their dissatisfaction with each other's behavior. The family learned to combine respect for difference with an attempt to honor and show compassion for one's family members.

Cross-cultural sensitivity can be a particularly thorny problem when considering the definition of child maltreatment. Anthropologist Emelie Olsen (1981) describes her concern for the health of Turkish infants swaddled in layers of heavy clothing on hot days, while noting that the Turkish mothers considered her neglectful for allowing her child to splash about in a homemade pool outside (which they believed might bring on chill and subsequent sickness). The idea that parents are responsible for their children is a concept that crosses cultures, despite the diversity in definitions of child maltreatment. Further, while cultures differ in their minimum criteria for maltreatment, each culture acknowledges behaviors that fall outside the boundary for acceptable parent-child treatment (Korbin, 1991). For many families who feel misjudged or misunderstood due to cultural differences on appropriate child rearing practices, it is useful to clarify the agreed-upon purposes of these possibly controversial practices. For example, the disciplinary choice might be designed to teach compassion, to instill responsibility, to encourage respect for others — goals that might be explicitly honored by the therapist. If this is done, it can be more acceptable for the family to re-examine alternative routes to these consensual ends that would be morally and culturally acceptable to the individual's culture and reference group.

Structure and Process of Trauma Treatment

Confidentiality in Treatment

The right of the parent or guardian to be kept informed of treatment at times leads therapists to disregard the needs of traumatized children for safe and confidential disclosure. The child's right to privacy should be considered, and the limits of confidentiality should be explained to children and guardians prior to disclosure of information. The critical issue should be the minimization of unnecessary betrayals or felt betrayals in the treatment of a child who has already been maltreated.

Therapy in the context of third party payment or open forensic cases produces special difficulties for the therapist attempting to balance the ethical duty to preserve the confidences of the patient with the various legal reporting requirements. The ethical requirement to preserve confidences crosses all the mental health professions, appearing in the Hippocratic oath that is one foundation for many ethics guidelines. ("Whatsoever I shall see or hear in the course of my profession…if it be what should not be published

abroad, I will never divulge, holding such things to be holy secrets.") For the therapist working with children, the issues are even more complex, since no therapeutic work with traumatized children should take place (ideally) without involvement of the parents or guardians. The older the child, however, the more responsibility is placed on the therapist to clarify the boundaries of required disclosure and to prepare the child client for the potential impact of therapist discussions with "outsiders."

As Myers (1992) notes, the law does not mandate disclosure of every facet of the child's therapy to the parent or guardian:

> Regardless of the child's age, the professional's first duty is to the child (American Psychological Association, 1981). This is so regardless of who pays for therapy. Thus the fact that the 15-year-old's parents pay for the youngster's psychotherapy does not entitle the parents to confidential information. A useful way to deal with potential conflicts over access to confidential information is to set the ground rules before therapy begins. When the child is developmentally capable of participating in this process, the child's input should be obtained. (p. 87)

Thus, from the beginning of therapy, the therapist of the older child can distinguish between that information which must be disclosed verbatim (for example, new abuse allegations, suicidal threats), that information which should be disclosed, but possibly in negotiated forms (for example, general information about how the child is progressing, how parental behavior might be changed to help the child), and information that need not be disclosed (for example, candid and negative descriptions of a particular parent-child encounter). Examples of child assents and informed consents to parents regarding child therapies are available in many published books (for example, Blau, 1999; Freedheim & Shapiro, 1999).

Confidentiality rules also apply to those supervising or consulting on child or adult cases. Any individual working with traumatized individuals should have an ongoing support system for case discussion and support.

The clinician should also be aware that a subpoena, although it may require the therapist's presence in court, does not waive client confidentiality automatically. If the child is not separately represented by counsel, the therapist may have to assert the privilege (that is, tell the judge that answering a particular question would require breaking a confidence to the patient). The judge will then decide whether the therapist must answer a specific question.

The therapist should provide the opportunity for the child to participate in a developmentally appropriate way in his or her own treatment process, both through informed assent, and through participation in the development and refinement of treatment goals.

The therapist's "first duty to the child" also means that the child's wishes, needs and goals should be considered in the treatment. These goals may be in conflict with those of the parents. If so, this conflict must be honestly addressed, such that the therapist can serve the client's needs, rather than solely those of his or her support system. Even younger children may be (and should be) part of the development of goals for therapy.

Boundaries and Touch in Trauma Treatment

The issues of boundaries and touch have special application to work with children (and especially abused children). Children are accustomed to behaviors that would be boundary violations if applied to an adult. They are often picked up, touched, or kissed without their permission, and they are told that resistance is "impolite." Abusive adults may exploit children's reliance on the adult definition of their boundaries, by telling them that abusive acts are "for their own good" or that submission to adult misuse is "respect for your elders." The victimized child thus may come to therapy with a strong tendency to cooperate with the adult's perceived wishes. In the case of sexually abused children, the child client may also be sexually provocative as an attachment strategy.

The therapist working with child victims of crime must have a principled approach to touch and other boundary behaviors. This is not a statement that children (or other clients) should not be touched; in fact, such a rigid stance might be harmful to child clients. Rather, the therapist has a responsibility to help children understand that they do have the right to make choices in regulating touch for themselves. Minimally, the therapist should ensure that the child understands that touch should occur in therapy only:

- When the child wants to touch or be touched (although this does not mean that the therapist will agree to inappropriate touch, even if it is requested), or
- To protect the child or the therapist.

This general principle implies that the therapist should consider the following dimensions before offering touch:

- Does the therapist know the child well enough to be able to predict the child's likely understandings of touch events?
- Is there time left in the session to talk about the touch event if it is a new form (for example, the first time child and therapist hug)?
- Has the child shown the capacity to tell the therapist when the therapist's actions are unwanted?
- Does the therapist feel manipulated or pressured into offering or accepting touch?
- Is the therapist certain to a reasonable degree that the form of touch offered is not sexually stimulating?

The final point is discussed extensively by Hunter and Struve (1998) in their guidelines for the ethical use of touch in psychotherapy. They — along with most writers — argue that it is inappropriately seductive to offer touch immediately or closely after a discussion of sexual concerns. It is also nontherapeutic to agree to unwanted touch; modeling the right to refuse coerced contact can be a critical intervention.

A point should also be made about the rigid "don't touch" stance that is at times offered as the most defensible ethical position in therapy. Subtle messages that touch is inherently associated with poor therapy might lead therapists to deny use of touch altogether and/or to fail to consider the underlying principles that will guide responses to touch requests. Therapists who are not comfortable with touch should avoid its use, and those who have not thought such issues through thoroughly should seek supervision and consultation about the forms of touch that might be acceptable within practice.

While the taboo against touch in therapy is understandable given concerns about sexualization of therapy or replacement of physical gratification for discussion of issues, the empirical evidence supports a more moderate position as above. With infants, a therapist noting absence or limited touch between parent and child should intervene directly to impact this interaction pattern, modeling appropriate touch for the parent as necessary. Although controversy is still present over specific findings, strong evidence exists that touch-deprived infants show later problems in affect regulation, anger management, and attachment (Ainsworth, 1978; Biggar, 1984; Harlow & Harlow, 1962; Hunter & Struve, 1998).

Countertransference and Trauma Treatment

The issue of "countertransference" — the therapist's feeling about the client — is complicated in the case of victimized children. In addition to monitoring one's harsh feelings toward parents who failed to protect or who were involved in abuse, the therapist should be aware of specific feelings about the traumatic event itself. Does the therapist believe that certain events are inherently impossible to assimilate or to overcome? Does the therapist believe that society "overreacts" to certain events? Such feelings about the trauma may be communicated subtly to the client, shaming or overwhelming the child. It is worth reading within the vast literature on personal survival stories in order (a) to come to understand the common patterns of traumatic

responding, and yet (b) to respect the diversity of understandings and outcomes possible with virtually any set of background circumstances.

Recent publications on countertransference and trauma have done much to advance this field of inquiry. Pearlman and Saakvitne's (1995) text is a particularly complete compendium of such reactions. Countertransference reactions are the foundations of many ethical violations including intrusions on the child or family (due to their wish to rescue) and inappropriate distancing from the child or family (due to fear or anger in the therapist). Self-evaluation and consultation are the key ingredients to preventing or mitigating countertransference-based treatment failures.

Consultation and the Standard of Care

The availability of consultation in trauma treatment is critical to ethical practice. This recommendation is so important that Brown et al. (1998) places it first among the dimensions related to performance that meets the standard of care. Consultation also relates to meeting the other standards they provide in their authoritative text. According to Brown, one or more of the following typically defines substandard treatments:

- Failure to secure consultation or supervision.
- Practice in isolation, the quality of which significantly departs from the quality of practice generally accepted by the peer community.
- Failure to document the treatment adequately.
- Failure to demonstrate knowledge of and adherence to mental health law and ethical principles.
- Failure to demonstrate knowledge of or ability to utilize in treatment the available authoritative clinical and scientific literature on trauma treatment.

The emphasis on consultation in these and previous guidelines reflects the continually evolving standard of care in psychotherapy and trauma treatment. Making the best use of colleagues as resources and sounding boards helps the practitioner to supplement the knowledge gained in reading and workshops and to assimilate the new information into an ethically sound and effective practice.

References

Ainsworth, M. (1978). *Patterns of attachment: A psychological study of the strange situation.* Hillsdale, NJ: Lawrence Erlbaum.

Beck, M. (1982). *Kidspeak: How your child develops language skills.* New York: New American Library.

Biggar, M. (1984). Maternal aversion to mother-infant contact. In C. Brown (Ed.). *The many facets of touch.* Skillman, NJ: Johnson & Johnson.

Blau, T. (1999). *The forensic documentation sourcebook.* New York: John Wiley and Sons.

Brown, D., Scheflin, A., & Hammond, D. C. (1998). *Memory, trauma treatment, and the law.* New York: W.W. Norton.

Bryant, S., & Range, L. (1997). Type and severity of child abuse and college students' lifetime suicidality. *Child Abuse and Neglect, 21,* 1169–1176.

Briere, J. (1992). *Child abuse trauma.* Newbury Park, CA: Sage.

Burgess, A., Hartman, C., & McCormack, A. (1987). Pathways and cycles of runaways: A model for understanding repetitive runaway behavior. *Hospital and Community Psychiatry, 38,* 292–299.

Chadwick, D., & Krous, H. (1997). Irresponsible testimony by medical experts in cases involving the physical abuse and neglect of children. *Child Maltreatment, 2,* 313–321.

Courtois, C. (1999). *Recollections of sexual abuse: Treatment principles and guidelines.* New York: W. W. Norton.

Dalenberg, C. (1996b). Fantastic elements in child disclosures of abuse. *APSAC Advisor, 3,* 1:5–10.

Davies, M., & Frawley, M. (1994). *Treating the adult survivor of childhood sexual abuse: A psychoanalytic perspective.* New York: Basic Books.

Elliott, D., & Briere, J. (1995). Posttraumatic stress associated with delayed recall of sexual abuse: A general population study. *Journal of Traumatic Stress, 8,* 629–647.

Freedheim, D., & Shapiro, J. (1999). *The clinical child documentation sourcebook.* New York: John Wiley & Sons.

Goldfeld, A., Mollica, R., Pesavento, B., & Farone, S. (1988). The physical and psychological sequelae of torture: Symptomatology and diagnosis. *Journal of the American Medical Association, 259,* 2725–2729.

Harlow, H. & Hawlow, M. (1962). The effect of rearing conditions on behavior. *Bulletin of the Menninger Clinic, 26,* 213–224.

Hunter, M., & Struve, J. (1998). *The ethical use of touch in psychotherapy.* Thousand Oaks: Sage.

Jacobs, J., & Dalenberg, C. (1998). Subtle presentations of post-traumatic stress disorder: Diagnostic considerations. *Psychiatric Clinics of North America, 21,* 835–846.

Koocher, G., & Keith-Spiegal, P. (1998). *Ethics in psychology: Professional standards and cases.* New York: Oxford University Press.

Korbin, J. (1991). Cross-cultural perspectives and research directions for the 21st century. *Child Abuse and Neglect, 15,* 67–77.

Mays, D., & Franks, C. (1985). *Negative outcome in psychotherapy and what to do about it.* New York: Springer Publishing.

Myers, J. (1992). *Legal issues in child abuse and neglect.* Newbury Park: Sage.

Olson, E. (1991). Socioeconomic and psychocultural contexts of child abuse and neglect in Turkey. In J. Korbin (Ed.). *Child abuse and neglect: Cross-cultural perspectives* (pp. 96–119). Berkeley, CA: University of California Press.

Pearlman, L., & Saakvitne, K. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors.* New York: W. W. Norton.

Pederson, P., Draguns, J., Lonner, W., & Trimble, E. (1989). *Counseling across cultures.* Honolulu: University of Hawaii Press.

Strupp, H., Wallach, M., & Wogan, M. (1964). Psychotherapy experience in retrospect: Questionnaire survey of former patients and their therapists. *Psychological Monographs: General and Applied, 78* (11, Whole No. 588).

Walker, A. (1994). *Handbook on questioning children: A linguistic perspective.* Washington, D.C.: American Bar Association Center on Children and the Law.